Programs must address the specific behavioral and medical domains a staff member must master for a thorough understanding and demonstration of competency in meeting the intensive needs of residents requiring ICF-MR-BRMM services. Initial and continuing direct care staff training shall include:

(i) Orientation to the facility or distinct part unit's status as a provider of ICF-MR-BRMM services, including the resident characteristics outlined in paragraph (C) of this rule, and the provider qualifications outlined in this paragraph of the rule; and

(ii) Information about the disorders/syndromes, behavioral phenotypes, and stages of disease progression affecting the current residents of the ICF-MR-BRMM provider; and

(iii) Accepted best practices and innovative approaches to meet these resident needs in both behavioral and medical domains.

(8) Service collaboration and day programming.

(a) Prior to approval as a provider of ICF-MR-BRMM services, the provider must demonstrate ability to collaborate with county boards of mental retardation and developmental disabilities and with others to provide service for individuals described in paragraph (C) of this rule.

(b) Prior to any individual's admission to an ICF-MR-BRMM, the provider must arrange for a suitable school or day program for the individual and submit the plan for such program to the ODJFS outlier coordinator.

(9) Preliminary evaluation.

Prior to the individual's admission, the provider must develop accurate assessments or reassessments by an interdisciplinary team which address the individual's health, social, psychological, educational, vocational, and chemical dependency needs and submit a copy of this preliminary evaluation to the ODJFS designated outlier coordinator.

(10) Transitional plan.

Due to the complex and intensive needs of individuals slated for admission to an ICF-MR-BRMM, the provider must perform sufficient planning prior to admission in order to assure the facility is ready and able to meet the

individual's health, safety and behavioral needs from the day of admission. This transitional plan must address major concerns and be submitted for review to the ODJFS designated outlier coordinator prior to the individual's admission.

(11) Initial assessment.

The provider must develop accurate assessments or reassessments by an interdisciplinary team which address the individual's health, social, psychological, educational, vocational, and chemical dependency needs within thirty days after admission, to supplement the preliminary evaluation conducted prior to admission described in paragraph (D)(9) of this rule; and submit a copy of this initial assessment to the ODJFS designated outlier coordinator.

(12) Individual plans, quarterly reports, and team meetings.

(a) Individual plan.

Within thirty days of the individual's admission, the provider must develop and submit to the ODJFS designated outlier coordinator a comprehensive, individualized plan. The plan shall be reviewed by the appropriate program staff at least quarterly and revised as necessary.

(b) Team meetings.

The facility shall notify ODJFS or its designee at least one week in advance of each full team meeting, and provide the ODJFS designated outlier coordinator with minutes of those meetings upon request.

(c) Quarterly reports.

The provider shall prepare and provide to the ODJFS outlier coordinator a quarterly report in a format approved by ODJFS that summarizes the individual's plan, progress, changes in treatment, current status relative to discharge goals and any updates to the discharge plan, including referrals made and anticipated time frames. A current copy of the individual's IP shall be available to the ODJFS designated outlier coordinator upon request.

(13) Discharge plan.

Within thirty days after admission, the provider must develop and submit to

the ODJFS designated outlier coordinator for approval a written discharge planning evaluation developed by the interdisciplinary team in conjunction with the individual and others concerned with the individual's welfare. The discharge plan must include a description of targeted behavioral and medical/health status indicators that would signify the resident could be safely discharged, recommendations for any counseling and training of the individual and family members or interested persons to prepare them for post-discharge care, an evaluation of the likely need for appropriate post-discharge services, the availability of those services, the providers of those services, the payment source for each service, and dates on which notification of the individual's needs and anticipated time frames was or would be made to the providers of those services.

(14) Reassessments of discharge plan.

When periodic reassessments of the discharge plan indicate that the individual's discharge needs have changed, the facility shall submit the results of the reassessments and the revised discharge plan to the ODJFS designated outlier coordinator within five working days following the revision.

(15) Continued stay denials.

If prior authorization is denied during an assessment that was requested for an individual who is already residing in the ICF-MR-BRMM unit, the provider agrees to move the individual to the first available ICF-MR bed that is not in the ICF-MR-BRMM unit for as long as ICF-MR services are needed, or until such time as a more appropriate placement can be made, and to accept payment for the provision of services at the ICF-MR level in accordance with rule 5101:3-3-78 of the Administrative Code.

(E) Prior authorization for services.

Reimbursement for ICF-MR-BRMM services covered by the medical assistance program is available only upon prior authorization from the department for each individual in accordance with the procedures set forth in this paragraph. These prior authorization procedures are in addition to the level of care review process as set forth in rule 5101:3-3-15.3 of the Administrative Code.

(1) Initial request.

In order to initiate the application process for the prior authorization, the provider of ICF-MR-BRMM services must submit to ODJFS or its designee, a written request for the prior authorization of ICF-MR-BRMM services. All requests must be in writing and may be submitted by mail or facsimile device.

No telephone requests will be honored. The request should be mailed or faxed to "the Bureau of Long Term Care Facilities, 30 East Broad Street, Columbus, Ohio 43215-3414" to the attention of the ODJFS outlier coordinator. The request is considered to be "submitted" when it is received by ODJFS or its designee.

(2) Initial application requirements.

It is the responsibility of the provider to ensure that all required information be provided to ODJFS as requested. Prior authorization for ICF-MR-BRMM services shall not be given until all of the initial application requirements set forth in this rule have been met. An initial application for the prior authorization of ICF-MR-BRMM services is considered to be complete after:

(a) A JFS 03142 form which requests prior authorization of medical services, has been appropriately completed; and

(b) A JFS 03697, or an alternative form specified by ODJFS, which accurately reflects the individual's current mental and physical condition and is certified by a physician, has been appropriately completed; and

(c) In accordance with the LOC review process for ICFs-MR set forth in rule 5101:3-3-153 of the Administrative Code, an ICF-MR LOC determination has been issued based upon a comparison of the individual's condition and service needs with the LOC criteria set forth in rules 5101:3-3-05, 5101:3-3-06, 5101:3-3-07, and 5101:3-3-08 of the Administrative Code; and a determination regarding the feasibility of community-based care has been made; and

(d) The ICF-MR-BRMM provider has submitted to the ODJFS designated outlier coordinator a JFS 03142 and supporting documentation exhibiting evidence that the applicant meets criteria listed in paragraphs (C)(3) to (C)(12) of this rule. The provider must retain a duplicate copy of all submitted documentation. Supporting documentation may include, but is not limited to, the preliminary evaluation, assessments and IP required prior to admission as set forth in paragraph (D) of this rule.

(3) Initial assessment.

The ODJFS determination shall be based on the completed initial application and may include a face-to-face visit by at least one representative of ODJFS

with the individual and, if applicable, the individual's representative and, to the extent possible, the individual's formal and informal care givers, to review and discuss the individual's care needs and preferences, and to obtain any additional information or documentation necessary to make the determination of eligibility for ICF-MR-BRMM services.

(4) Prior authorization determinations.

Based upon a comparison of the individual's condition, service needs, and the requested placement site, with the eligibility criteria set forth in paragraph (C) of this rule, the ODJFS outlier prior authorization committee shall conduct a review of the application, assessment report, and supporting documentation about the individual's condition and service needs to determine whether the individual is eligible for ICF-MR-BRMM services.

(5) Notice of determination.

When the prior authorization request has been processed by the ODJFS outlier prior authorization committee indicating approval or denial of the request for authorization of reimbursement, or deferral of the decision, notices shall be sent via mail or electronic facsimile (FAX), that include all of the determinations made, and the individual's state hearing rights, in accordance with Chapter 5101:6-2 of the Administrative Code, to the individual, the individual's legal guardian and/or representative (if any), and the provider. The provider may perform any service(s). However, reimbursement by ODJFS is limited to services approved as indicated in the approval letter.

(a) Denial.

When a request for prior authorization of reimbursement for ICF-MR-BRMM services is denied, the department will issue a notice of medical determination and a right to a state hearing. A copy of this denial notice will be sent to the CDJFS to be filed in the individual's case record. The notice shall also include an explanation of the reason for the denial.

(b) Approval.

When a request for prior authorization of reimbursement for ICF-MR-BRMM services has been approved, the department will issue an approval letter which will include an assigned prior authorization number. The notice shall also include the number of days for which the ICF-MR-BRMM placement is authorized; the date on which payment is

authorized to begin; and the name, location, and phone number of the staff member of ODJFS who is assigned to monitor the individual's progress in the facility, participate in the individual's interdisciplinary team, and monitor implementation of the individual's discharge plan. A copy of this approval notice will be sent to the CDJFS to be filed in the inidividual's case record.

(i) Authorization for initial length of stay.

Individuals who are determined to have met the eligibility criteria set forth in paragraph (C) of this rule may be approved for an initial stay of up to a maximum of six months, or up to one hundred eighty-four days. The number of months or days that is prior authorized for each eligible individual shall be based upon the submitted application materials, consultation with the individual's attending physician, and/or any additional consultations or materials required by the assessor to make a reasonable estimation regarding the individual's probable length of stay in the ICF-MR-BRMM unit.

(ii) Authorization for continued stays.

Continued stay determinations shall be based on reports from the facility submitted to the ODJFS designated outlier coordinator regarding critical events and the status of the individual's condition and discharge planning options, face-to-face assessments conducted by ODJFS and other collaborative information determined by the ODJFS outlier prior authorization committee. When ODJFS determines that the individual continues to meet the eligibility criteria set forth in paragraph (C) of this rule. Continued stays may be approved for maximum increments of six months, up to one hundred eighty-four days.

(6) Discharges.

The individual is expected to be discharged to the setting specified in the individual's discharge plan at the end of the prior authorized initial or continued stay, and progress toward that end shall be monitored by ODJFS or its designee throughout the individual's ICF-MR-BRMM unit stay. However, in the event that it is not possible to implement the individual's discharge plan, coverage of ICF-MR-BRMM services may be extended beyond the previously approved length of stay via the submission to ODJFS of a written request for the continuation of ICF-MR-BRMM services by the provider. Unless there is a significant change of circumstances within the week

preceding the expected discharge date which prevents implementation of the discharge plan, such requests must be submitted at least one week prior to the last day of the previously authorized stay.

(F) Provider agreement addendum.

After ODJFS has approved the ICF-MR as a qualified provider of ICF-MR-BRMM services, both parties shall sign the JFS 03642, an addendum to the Ohio medical assistance program's long term care facility provider agreement (JFS 03623). This addendum must also be signed as a part of each subsequent annual provider agreement renewal with ODJFS, unless the provider chooses to withdraw as a provider of this ICF-MR outlier service or is determined by ODJFS to no longer meet the qualifications set forth in paragraph (D) of this rule.

(G) Authorization of payment.

Authorization of payment to an eligible provider for the provision of ICF-MR-BRMM services shall correspond with the effective date of the individual's ICF-MR-BRMM prior authorization approval specified by the ODJFS outlier prior authorization committee, but shall not be earlier than the effective date of the individual's LOC determination. This date shall be:

(1) The date of admission to the ICF-MR-BRMM unit if it is within thirty days of the physician's signature on the JFS 03697 or an alternative form specified by ODJFS; or

(2) The date of ICF-MR-BRMM prior authorization approval, if the individual was already a resident of an ICF-MR-BRMM but was using another payer source; or

(3) A date other than that specified in paragraph (G)(1) or (G)(2) of this rule. This alternative date may be authorized only upon receipt of a letter by the ODJFS designated outlier coordinator which contains a credible explanation for the delay from the originator of the request for the prior authorization of ICF-MR-BRMM services. If the request is to backdate the LOC and ICF-MR-BRMM eligibility determination more than thirty days from the physician's signature, the physician must verify the continuing accuracy of the information and need for inpatient care either by adding a statement to that effect on the JFS 03697 or alternative approved form, or by attaching a separate letter of explanation.

(H) ~~Initial contracted rate.~~Initial and subsequent contracted rates.

ODJFS will establish the initial contracted rate and contracted rates subsequent to the initial rate year in accordance with rule 5101:3-3-25 of the Administrative Code.

~~(I) The initial rate for a newly approved provider of ICF-MR-BRMM services will be set in accordance with rule 5101:3-3-86 of the Administrative Code.~~

~~(2) ODJFS will establish the initial contracted rate in accordance with rule 5101:3-3-25 of the Administrative Code no later than ninety days after ODJFS receives all the required information. The initial contracted rate will be implemented retroactively to the initial date services were provided pursuant to the ICF-MR-BRMM provider agreement.~~

~~(a) The following information may be submitted as soon as the provider receives notification from ODJFS of the effective date of the ICF-MR-BRMM provider agreement, but should be submitted within ninety days of the provider agreement's effective date.~~

~~(i) The projected cost report budget for the initial year of operation; and~~

~~(ii) The current calendar year capital expenditure plan, including a detailed asset listing; and~~

~~(iii) The current calendar year plan for basic staffing patterns, using a format to be approved by ODJFS, that includes the staff schedule by shift, number of staff in each position, staff position descriptions, base wage rates, and a brief explanation of contingencies that may require adjustments to these basic staffing patterns.~~

~~(b) The following information should be submitted no later than ninety days after the end of the actual initial three months of operation as an ICF-MR-BRMM:~~

~~(i) A cost report for the period of the actual initial three months of service; and~~

~~(ii) Current individual plans (IPs) for residents to be served in the period for which a rate is being established.~~

~~(I) Contracted rates subsequent to the initial rate year.~~

~~(1) The contracted rate will be effective for the fiscal year beginning on the first of July and ending on the thirtieth day of June of the following calendar year.~~

~~(2) ODJFS will establish the contracted rate in accordance with rule 5101:3-3-25 of~~

~~the Administrative Code no later than the thirty-first day of July of the calendar year following the period encompassed by the year-end cost report, unless the provider fails to submit all required information by the thirty-first of March. In that case, ODJFS will assign to the outlier facility the simple average rate paid to ICFs-MR of fewer than nine beds for services delivered during the month of July, and establish the contracted rate no later than ninety days after all information is submitted, but no earlier than the first of August. The contracted rate will be implemented retroactively to the beginning of the fiscal year.~~

~~(3) The following information must be submitted by the provider to the "Bureau of Long-Term Care Facilities" in order to establish the contracted rate for any year subsequent to the year of the initial contracted rate:~~

~~(a) Case mix data.~~

~~Completed JFS 02221, "Ohio ICF-MR individual assessment form answer sheets" must be completed and submitted for each resident of the ICF-MR-BRMM in accordance with the requirements and deadlines set forth in rule 5101:3-3-75 of the Administrative Code; and~~

~~(b) IPs.~~

~~Current individual plans (IPs) for residents to be served in the period for which a rate is being established, filed by the thirty-first of March of the current calendar year; and~~

~~(c) Cost report and budget information.~~

~~The actual year-end cost report shall be submitted within the deadline specified in accordance with rule 5101:3-3-20 of the Administrative Code. The current calendar year cost report budget shall be submitted by the thirty-first of March of the current calendar year, in conjunction with the previous calendar year's actual cost report; and~~

~~(d) Financial statement information.~~

~~(i) For-profit providers shall submit a balance sheet, income statement, and statement of cash flows for the ICF-MR-BRMM no later than the thirty-first of March of the following calendar year relating to the previous calendar year's actual cost report submitted in accordance with paragraph (I)(3)(c) of this rule; or~~

~~(ii) Not-for-profit providers shall submit a statement of financial position, statement of activities, and statement of cash flows for the ICF-MR-BRMM no later than the thirty-first of March of the following calendar year relating to the previous calendar year's~~

~~actual cost report submitted in accordance with paragraph (I)(3)(e) of this rule; and~~

~~(e) Capital expenditure plan.~~

~~The current calendar year capital expenditure plan, including the detailed asset listing, shall be filed by the thirty-first of March of the current calendar year; and~~

~~(f) Staffing pattern plan.~~

~~The current calendar year plan for basic staffing patterns, using a format to be approved by ODJFS, that includes the staff schedule by shift, number of staff in each position, staff position descriptions, base wage rates, and a brief explanation of contingencies that may require adjustments to these basic staffing patterns shall be filed by the thirty-first of March of the current calendar year; and~~

~~(g) Board minutes.~~

~~Approved board minutes from the legal entity holding the provider agreement and all other related legal entities for the calendar year covered by the actual cost report shall be filed by the thirty-first of March of the following calendar year.~~

Effective: 07/01/2004

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CERTIFIED ELECTRONICALLY

Certification

06/21/2004

Date

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